proud past, promising future
CLARK COUNTY
WASHINGTON

Clark County Regional Support Network Policy Statement

Policy No.:	**QM18**
Policy Title:	**Sentinel Event Review and Negative Media Coverage**
Effective Date:	**September 1, 2001**

Policy: Clark County Regional Support Network (CCRSN) shall ensure that all sentinel events that occur within its provider network are reported and reviewed for purposes of quality improvement and coordination of response to negative media coverage. CCRSN contracted providers shall establish policies and procedures for sentinel event reporting and review that includes timely reporting of events to CCRSN. If negative media coverage is expected or occurs, CCRSN shall notify the WA Mental Health Division according to its requirements.

Reference: RCW42.17.310 (1)(j), RCW 42.70.510, RCW 4.24.250 WA Mental Health Division CCRSN contract, Clark County Provider Contract Agreement, Special Terms and Conditions, Clark County Media Communication Policy and Procedure, Clark County Regional Support Network Policy and Procedure Manual: QM18-A Sentinel Event Report Form, QM18-B Sentinel Event Review- 30 Day Review Form, CCRSN Report to Washington Mental Health Division - Negative Media Coverage Report Template, Clark County Public Information Office Policy and Procedure: News Media Policy

Definition:

Sentinel events are incidents that involve significant bodily harm to consumers, harm to others caused by consumers, or potential harm. Events that must be reported and reviewed include:

1. Homicide or attempted homicide, when the consumer is the perpetrator or victim.
2. Completed suicide or suicide attempts which are potentially lethal and require medical attention.
3. Unexpected or suspicious death of a consumer.
4. Injuries to consumers requiring medical attention while under direct agency care.
5. Significant damage to agency property by consumers that requires the filing of an insurance or police report.
6. Serious threats of harm made by a consumer, invoking provider duty to warn, and/or serious physical assaults which occur on agency property.
7. Abuse or neglect of a consumer by an employee, student intern, or volunteer.
8. Loss of services, including crisis services and/or residential sites.

Procedure:

Provider Responsibilities- Reporting to CCRSN and Clinical Review

1. The CCRSN contracted provider shall notify CCRSN of a sentinel event by telephone within 24 hours of learning about the incident, giving the consumer's name, birth date or age, and nature of the incident. The provider shall fax a written report to CCRSN to the attention of the Quality Manager or designee, no later than 24 hours after the event, using the *Sentinel Event Report* form (QM18-A) provided by CCRSN.

2. Within 30 days of the sentinel event, the provider shall conduct its own internal review of the event and forward summary information about the review to CCRSN using the *Sentinel Event Review* form (QM18-B) provided by CCRSN. A copy of the coroners report shall be forwarded to CCRSN in cases of suspicious or unexpected death, or if requested.

3. In conducting a sentinel event review, the provider shall convene a review committee that involves the staff most knowledgeable about the incident and the consumer, the Clinical Supervisor, the Clinical Director, and medical staff. The review committee shall adequately address and document the following:
    a) The appropriateness of treatment provided and crisis plan (if completed).
    b) Appropriateness of the intensity of care.
    c) Summary of interventions to date and progress toward treatment goals.
    d) Immediate treatment needs of the consumer, if relevant.
    e) Recommendations, if any, for changes in provider or RSN policy and procedures that might prevent recurrences of similar events or improve quality of care.
    f) Recommendations about other quality improvement activities at the provider and/or RSN level as a result of the review.

4. Files of sentinel event reviews shall be kept separately from the clinical record and stored in a locked cabinet at the provider agency. The files shall be made available for on-site review by CCRSN in the event CCRSN conducts its own review of a sentinel event.

CCRSN Responsibilities - Reporting to WA Mental Health Division and Communication with the Media

5. The CCRSN Quality Manager or designee shall review the initial Sentinel Event Report to determine whether negative media attention might result. Incidents that involve homicide, attempted homicide, completed suicide, abuse or neglect of a consumer by an employee, student intern, or volunteer, loss of the Clark County Crisis Line, loss of a mental health provider and/or mental health services (including residential) or any other incident that involves negative media coverage shall be reported to the WA Mental Health Division (MHD).

6. The CCRSN Quality Manager or designee shall notify the WA MHD services Chief or his/her designee on the same business day of learning of a sentinel event involving negative media coverage, or as soon as possible on the next business day if the event occurs after business hours. The CCRSN Quality Manager or designee who receives the report shall also notify the Clark County Department of

Community Services Communications Coordinator responsible for coordinating Department response to the media.

7. Notification to the MHD shall be made using the *CCRSN Report to Washington Mental Health Division- Negative Media Coverage Report* form (QM18-C) and include a description of the event, any actions taken in response to the incident and for what purpose, and any implications for the service delivery system.

8. When requested by the MHD, a written report shall be provided within 2 weeks of the original notification to provide information about CCRSN and/or provider actions to prevent or lessen the possibility of future similar incidents.

9. The CCRSN Quality Manager or other CCRSN staff who receives notification of a sentinel event involving potential negative media coverage shall notify the Clark County Department of Community Services Public Affairs and Communications Coordinator in accordance with state and federal confidentiality laws. The Public Affairs and Communications Coordinator shall follow Clark County Public Information Office procedures in coordinating media response if necessary.

CCRSN Clinical Review and Quality Improvement

10. In the event CCRSN becomes aware of a sentinel event involving a CCRSN- funded provider before the primary treating provider, CCRSN shall follow the same reporting and review procedures described under network provider responsibilities in this policy.

11. The CCRSN Quality Manager and Clinical Services Manager shall review the *Sentinel Event Report* form (QM18-A) upon receipt to determine whether a case review and/or chart review, and/or consultation with the CCRSN Medical Director is warranted. If needed, the CCRSN Medical Director and/or Clinical Manager shall conduct a chart review and/or case review as expeditiously as the situation requires.

12. The CCRSN Quality Management and Grievance Coordinator shall track the completion of the *Sentinel Event 30 Day Review* form (QM18-B) by the Network Provider to ensure the provider review took place as required.

13. Copies of the completed form shall be forwarded to the Quality Manager, Medical Director and Clinical Services Manager for review. If the review determines that more information is needed to assess appropriateness of treatment or quality of care concerns, the Medical Director will schedule a chart review and/or case review.

14. The CCRSN Quality Manager shall provide a quarterly summary report of Sentinel Events to the Quality Management Committee that includes number and type of events, aggregated issues, trends, and recommendations for service improvement.

Approved By: _____ Date: 11-15-05

Michael Piper, Director
Clark County
Department of Community Services